Health Care Group - Moving Towards Accountability: A Proposed Plan

Submitted to:
Health Care Group Administration,
Arizona Health Care Cost Containment System

Submitted by:
Mercy Care Plan
University Physicians, Incorporated

August 2001

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Executive Summary

The Health Care Group (HCG) has been an innovative, cost-effective way to provide health insurance to the small group marketplace in Arizona since 1988. Beginning in 1999, HCG began receiving, on average, approximately $8 million annually in State subsidies to reduce the cost of HCG insurance to participating members. With the advent of state subsidies, it is incumbent upon the State to ensure that it maximizes the effectiveness of those State subsidies, consistent with the State's doctrine of helping the most needy of its citizens while encouraging personal responsibility.

The two current HCG plans, Mercy Care Plan and University Physicians, Incorporated, have produced this briefing paper for the Health Care Group Administration of the Arizona Health Care Cost Containment System (AHCCCS). This paper should also be considered in light of the larger health care reform discussion currently being undertaken by the Statewide Health Care Insurance Plan Task Force (Task Force). The Task Force is tasked with the responsibility of developing plans for providing Arizona uninsured populations with affordable, accessible health insurance. An important point for the Task Force and the Legislature to consider during these deliberations is the lack of a permanent funding source for the HCG program beyond state fiscal year 2002 (SFY02). Without a permanent funding source for HCG, approximately 12,000 Arizonans who have health care coverage through HCG will lose their coverage and potentially become uninsured.

This paper begins with a discussion of the mission of the HCG program, including the origins of the program, and the program's goals. This is followed by a narrative description of the Proposed Plan in the context of the previously outlined program goals. Finally, the Proposed Plan's specific design changes are examined from the viewpoint of the uninsured. The changes represent the minimum program changes that would need to be implemented to ensure continued participation in the HCG program by the two currently contracted health plans, Mercy Care Plan and University Physicians, Incorporated. It is important to note that the major programmatic changes proposed will require legislative intervention.

HCG's Original Mission Summary

HCG was created to provide affordable and accessible health care coverage to small businesses with 50 or fewer employees and political subdivisions within the state of Arizona.

Origins of the Program

HCG was developed to help reduce the number of uninsured individuals in the State. HCG acts as a safety net. It provides a way for individuals to receive health care when it is needed rather than waiting until they are seriously ill, cannot work because f the

illness, and are forced to spend down to AHCCCS or other State/Federal assistance programs. HCG is an employment-based health care coverage program. Covered individuals must be self-employed, working for a small business, or work for a political subdivision. Dependents of these employees are also covered. Program efforts are directed at encouraging small employers to offer coverage to their employees. This benefits the state by:

- Reducing the strain of uncompensated care on hospitals, community health centers, and individual practitioners,
- Maintaining a health, productive work force and solid tax base, and
- Providing an opportunity for Arizonans to lead a healthier, more productive life.

Commercial insurance companies have been unwilling to pick up the risk of insuring the small employer marketplace, and in many instances, without HCG as a safety net, this population would be left without an option for coverage. The small employer marketplace is just one segment of the health insurance market that does not have access to the health care coverage – because it is too expensive or simply not available to them. The result of this lack of coverage places an increasing burden on the already over-burdened health care system as costs are shifted to other payors:

- Medical costs are increasing for all Arizonans to cover uncompensated care of the uninsured,
- Higher taxes are being assessed to pay for State/Federal assistance programs when indigent qualify or spend down to qualify for indigent care programs, and
- Insurance premiums of the insured are increasing to make up the difference.

Many forms of health care reforms are being considered at the State and Federal level, yet no one will address the problems of all of the uninsured. Until such time that a solution can be crafted that specifically addresses the needs of the small employer uninsured, HCG provides a much needed level of coverage to Arizona's small employer groups, especially sole proprietors and businesses with one employee. And the coverage has shown to be affordable, easily accessible, and efficiently provided from both an administrative and programmatic perspective.

Goals of the Program

The HCG Administration developed five mandates to actuate the goals and objectives of the program. The mandates drive administrative and program management and supply the framework from which quantifiable performance measures can be evaluated. The five mandates are:

1. Reduce the number of uninsured by offering health care coverage to small business groups
2. Provide Statewide accessible coverage
3. Maintain affordable premium levels
4. Monitor health plan's performance
5. Promote public awareness of the benefits of health care coverage and the availability of the HCG coverage

Within each of these mandates, HCG Administration is responsible for the administrative component of the program and the participating health plans are responsible for programmatic component of the program. Performance measures have been developed and are available demonstrating the value of both components of the program.

HCG Proposed Plan - Plan Design Summary

This section contains a brief description of the Proposed Plan recommended by the HCG plans. The Proposed Plan Design can be grouped into four major components;

- Program Design – the administrative structure of the program such as eligibility determination;
- Target Population – those eligible individuals who actually enroll;
- Benefit Package – the services provided to the enrolled population; and
- Service Delivery Network – how the services will be provided, primarily a choice of fee-for-service versus managed care.

Program Design

To improve the accountability of the program and continue to be administratively efficient, the Proposed Plan recommends four major changes to the HCG program in the areas of eligibility, number of plans offered, the division of administrative responsibilities, and the underwriting methodology. A major existing component of the current HCG program's accountability, its Prepaid Plan requirement, remains unchanged.

Eligibility Changes

As the HCG program has received subsidies from the State General Fund in State-only dollars, the HCG eligibility process should be altered to ensure that only those with no other public programs available to them are receiving State-only subsidies. To do this, the eligibility process must be changed to gather sufficient household income information to make a preliminary eligibility determination for all joint State/Federal programs. In this manner, the HCG is more accountable to the State by ensuring that Federal dollars are maximized. Implementing a hierarchical eligibility process will require a substantial expansion in the State's administrative effort.

Number of Benefit Options Offered

One of the reasons HCG has been successful to date has been its low administrative overhead. To continue to be administratively efficient, HCG proposes to streamline the benefit options offered into a single uniform coverage option offered Statewide. Employers will be offered a single benefit design, with no ability to modify or alter the covered benefits or benefit levels. A single benefit option will be easier for the HCG Administration to administer.

Division of HCG Administrative Responsibilities

The HCG Plans propose reorganizing the administrative structure of the program to reflect the new accountability to be attached to the HCG program. The HCG Administration would expand its role and assume all of the roles of a clearinghouse, assuming the primary responsibility for eligibility determination, enrollment, and disenrollment. Again, for HCG Administration to undertake these additional administrative functions would require a substantial expansion of their administrative dollars and resources. To do this, additional administrative funding sources would need to be identified. Currently, the HCG Administration is funded completely out of member contributions and this funding would be insufficient to cover the additional responsibilities proposed here. The HCG Plans would then focus solely on the delivery and management of the care.

Underwriting Methodology

To incorporate the concept of accountability into the program, it is essential to have a premium structure that varies by income. A revised underwriting methodology is necessary to develop a premium structure that varies by income. To avoid issues of adverse selection, the underwriting methodology must also factor in demographic age banding. The resulting new rate setting methodology would be comprised of a base three-tier rate structure that would vary slightly by county and two adjustment factors based on the employee's household income and the employee's age.

Prepaid Plan

To reinforce personal responsibility, HCG members will continue to be required to pay their premiums by the first of the month prior to the month of service.

Target Population

The target population for the HCG population continues unchanged from that of current legislation; the small employer group marketplace with between 1 and 50 employees and political subdivisions regardless of size.

Benefit Package

Services of the Proposed Plan will be provided through a single uniform coverage approach built on a managed care service delivery network. Employers will have only one benefit plan to choose from and will not be offered riders or modifications. All covered services, copays, and benefit levels will be identical Statewide for each participating health plan. The benefit design of the Proposed Plan is outlined in the following table:

Description	
Covered Services	Hospital, physician, emergency room (ER), pharmacy, ambulance, preventive services, other
Additional Services	Medically necessary DME, family planning services
Excluded Services	Mental health/behavioral health, chiropractic, transplants, and skilled nursing facility
Benefit Levels	$2 million lifetime maximum
Cost-Sharing Provisions	
Copay Only	$100 per inpatient admission; $100 per surgery in licensed ambulatory surgical center; $100 for all use of ER; $40 for urgent care facilities; $20 for physician, $15 generic/$30 brand for pharmacy; $10 for approved, scheduled well-care visits

Service Delivery Network

In keeping with the current service delivery approach, the network will continue to be a managed care delivery system based on the gatekeeper model. The services, to be delivered through a managed care service delivery network, will be subject to the use of a primary care gatekeeper model, prior authorization requirements, and utilization management techniques consistent with the current small employer marketplace.

Personal Responsibility Components

As mentioned above, all individuals who apply to the HCG program through their employers must submit adequate documentation for the HCG administration to determine their eligibility for other joint State/Federal programs. To ensure that State-only dollars are used only those individuals for whom no other publicly funded health insurance options exist, only those individuals who are ineligible for Federal programs will be enrolled in the HCG program.

The premium structure will use a incremental scale based on employee age and household income. As the household income increases, so will the premium. As a result of implementing hierarchical eligibility, the scale will be coordinated with existing State/Federal programs' income eligibility guidelines. The sliding scale will be sloped so that the low income households (less than 300% of the FPL) will be receiving the largest subsidy, the near poor (between 300% and 399%) will receive a smaller subsidy, and those with incomes above 400% will receive no subsidy and could potentially be subsidizing the cost of the program.

Methodology

AHCCCS requested that the HCG Administration, in conjunction with its contracted HCG plans, develop a briefing paper on the HCG program to present proposed changes to the HCG program. This briefing paper will be shared with the Statewide Health Care Insurance Plan Task Force. The proposed changes developed by the HCG plans are designed to make it more accountable for the State subsidies received and more focused on the State's doctrine of personal responsibility. The proposed changes were developed through a series of four working meetings between the HCG plans and the HCG Administration. The changes represent the minimum program changes that would need to be implemented to ensure continued participation in the HCG program by the two currently contracted health plans, Mercy Care Plan and University Physicians, Incorporated.

HCG's Original Mission

HCG was created to provide affordable and accessible health care coverage to small businesses with 50 or fewer employees and political subdivisions within the state of Arizona.

To be successful in achieving the goal of appealing to the small group target market, it essential to understand the programs' original mission and then how the proposed changes refocus HCG on its original mission. To do this, in this section of the paper, first the origins of the program are examined and then the program's goals are examined. In the final section, the proposed changes are reviewed relative to their ability to achieve those program goals.

Origins of the Program

HCG was developed to help reduce the number of uninsured individuals in the State. HCG acts as a safety net. It provides a way for individuals to receive health care when it is needed rather than waiting until they are seriously ill, cannot work because f the illness, and are forced to spend down to AHCCCS or other State/Federal assistance programs. HCG is an employment-based health care coverage program. Covered individuals must be self-employed, working for a small business, or work for a political subdivision. Dependents of these employees are also covered. Program efforts are directed at encouraging small employers to offer coverage to their employees. This benefits the state by:

- Reducing the strain of uncompensated care on hospitals, community health centers, and individual practitioners,
- Maintaining a health, productive work force and solid tax base, and
- Providing an opportunity for Arizonans to lead a healthier, more productive life.

Many small businesses are unable to obtain group coverage because:

- Commercial insurance carriers have elected to avoid the small group market through insurance practices such as medical/experience underwriting, mandatory employer contributions, and minimum group size requirements. Few insurance carriers market to businesses with 2- 5 employees.
- The Department of Insurance and the insurance companies they regulate do not recognize sole proprietors or businesses with one employee as a group and therefore do not provide group coverage to them.
- Medical underwriting escalates the small groups' premium rates to unaffordable levels even though Federal legislation, The Health Insurance and Portability and Accountability Act of 1996 (HIPAA) mandates guaranteed coverage.

Commercial insurance companies have been unwilling to pick up the risk of insuring the small employer marketplace, and in many instances, without HCG as a safety net, this

population would be left without an option for coverage. The small employer marketplace is just one segment of the health insurance market that does not have access to the health care coverage – because it is too expensive or simply no available to them. The result of this lack of coverage places an increasing burden on the already over-burdened health care system as costs are shifted to other payors:

- Medical costs are increasing for all Arizonans to cover uncompensated care of the uninsured,
- Higher taxes are being assessed to pay for State/Federal assistance programs when indigent qualify or spend down to qualify for indigent care programs, and
- Insurance premiums of the insured are increasing to make up the difference.

Many forms of health care reforms are being considered at the State and Federal level, yet no one will address the problems of all of the uninsured. Until such time that a solution can be crafted that specifically addresses the needs of the small employer uninsured, HCG provides a much needed level of coverage to Arizona's small employer groups, especially sole proprietors and businesses with one employee. And the coverage has shown to be affordable, easily accessible, and efficiently provided from both an administrative and programmatic perspective.

HCG's Program Goals

The HCG Administration developed five mandates to actuate the goals and objectives of the program. The mandates drive administrative and program management and supply the framework from which quantifiable performance measures can be evaluated. The five mandates and how the HCG program addresses them are:

1. Reduce the number of uninsured by offering health care coverage to small business groups - HCG is the only health care provider that recognizes groups of one as a group. Minimal group size coverage through a commercial carrier is two. HCG is dominated by very small groups – 91% of the covered groups are 3 and less employees. HCG also encourages employer contributions but does not mandate them;
2. Provide Statewide accessible coverage – Until the recent departure of one of the three participating health plans, HCG was able to offer statewide coverage to all Arizonans. The HCG Administration is currently examining the most appropriate vehicle continue to provide Statewide access.
3. Maintain affordable premium levels - There is no medical underwriting at the time of enrollment. HCG premium rates and annual increases are based on the cost of providing services to all enrollees and not on the medical condition of a particular enrollee at the time of enrollment
4. Monitor health plan's performance – The HCG Administration has developed an extremely comprehensive data set combining person-level eligibility data with detailed claims and utilization data for all HCG members. Combined with a sophisticated decision support system, HCG Administration has the capability to

quickly provide management reporting information on the participating health plans' performance in the areas of access to care, utilization management, and coordination of care. As part of the legislation making State funds available to cover potential losses incurred by participating health plans, those plans are required to submit audited financials specific to the HCG line of business. In addition, the plans submit a detailed quarterly financial reporting package that allows the HCG Administration to continually monitor the health plans' financial performance. In addition, in conjunction with AHCCCS biannual health plan review process, HCG Administration staff review the HCG operations of each participating health plan every two years.

5. Promote public awareness of the benefits of health care coverage and the availability of the HCG coverage - HCG's decision support system generates monthly and ad hoc reports on the enrollment/disenrollment trends, monitoring changes in group size, health status at time of enrollment, and evaluating average group premium rates. These reports are also used to study trends over several years by providing cross-sectional and longitudinal tabulation of data on past and current members. The HCG Administration has used these reporting capabilities to build a regular management reporting package that it uses to keep the AHCCCS Administration and the Legislature fully informed of the program's current status.

Within each of these mandates, HCG Administration is responsible for the administrative component of the program and the participating health plans are responsible for programmatic component of the program. Performance measures have been developed and are available demonstrating the value of both components of the program.

While innovative State and Federal health care reforms are being designed and implemented and commercial insurance programs are in compliance with HIPAA, there remains a segment of the small group market that will not be reached, very small groups with 1 – 3 employees. For the most part, this population remains virtually unserved or underserved.

HCG is available and positioned to cover these very small employer groups. Without HCG, many small businesses would be unable to find affordable health care for their employees.

HCG Proposed Plan

This section reviews the Proposed Plan by comparing it to other, typical small employer plans, and relying on the collective experience of the HCG Plans in the health care coverage market. To ensure a complete and systematic discussion of the major changes within the Proposed Plan Design, the changes were grouped into the four components of Plan Design. These components, also known as the Determinants of Risk, ultimately determine the final plan design of any health insurance program and the resulting premium necessary to support that insurance program.

- Program Design – the administrative structure of the program such as eligibility determination;
- Target Population – those eligible individuals who actually enroll;
- Benefit Package – the services provided to the enrolled population; and
- Service Delivery Network – how the services will be provided, primarily a choice of fee-for-service versus managed care.

The outline of this section follows that of the previous sections by discussing the plan design and personal responsibility components of the Proposed Plan. Within each of the components of plan design, the major changes are outlined with narrative attached describing the issues surrounding the proposed changes.

Plan Design

There were several over-arching themes agreed upon by the HCG plans in developing the Proposed Plan;

- The Proposed Plan had to be accountable for the State subsidies now being received;
- The Proposed Plan could not violate the original intent of the HCG program to encourage personal responsibility;
- The Proposed Plan must direct any subsidies, if necessary for the program's continued existence, to the most needy based on income
- The Proposed Plan must continue to provide an insurance vehicle for the small group marketplace where none currently exists due to affordability or lack of product availability

Program Design

Hierarchical Eligibility

To improve the accountability of HCG in light of its recent State subsidies, the major revision to the HCG program is to develop a hierarchical eligibility determination to

ensure that only those individuals with no other joint State/Federal programs available to them are receiving State-only subsidy dollars.

The implementation of hierarchical eligibility is also consistent with the State's goal of using a universal application for eligibility processing and streamlined eligibility determinations. Under the universal application approach, eligibility processing for the multitude of joint State/Federal programs is transparent to the applicant. All the applicant knows is that the State is screening the applicant for ALL public programs to find the program most advantageous to the applicant and the State, simultaneously. This saves the applicant time and needless duplication and will result in higher presentation rates. The hierarchical eligibility will also allow the State to maximize State and Federal funding so that more individuals can be offered coverage. Implementing a hierarchical eligibility process will require a substantial expansion in the State's administrative effort.

Number of Benefit Options Offered

The decision to offer a single benefit option has many implications, both positive and negative. Individual participation will likely be better when more than one option is offered. Because the uninsured sub-populations in any given county have different needs and concerns, it is beneficial to include multiple plan options.

Offering more than one form of benefit option does have its drawbacks. The program is more complex to administer. Likewise, more educational materials will need to be developed and distributed in order to aid individuals in choosing a specific benefit plan. Even with educational material, the complexity of the choices may lead to misunderstanding. Furthermore, the risk of the populations enrolling in the various coverage plans may vary dramatically. This occurrence, often referred to as selection, can create significant imbalances between the plans. These imbalances lead to higher premiums in certain plans and create concerns for insurance providers that are left with the highest cost individuals.

The past experience of HCG is consistent with that of other States when offering multiple plans; the plan most resembling the dominant plan in the marketplace is also the most dominant plan for the subsidized program, typically garnering 85-95% of the enrollment. The administrative complexity associated with additional plans is not warranted by the minimal additional enrollment gained.

Division of HCG Responsibilities

Based on the proposed changes to improve the accountability of the HCG program for its State subsidies, the division of responsibilities should change between the HCG Administration and the HCG Plans. To achieve the improved accountability, the HCG program must have a much closer linkage to the other joint State/Federal programs administered by AHCCCS. In addition, To improve the coordination of the HCG program with other public programs in Arizona, HCG needs a administratively efficient centralized clearinghouse function.

The HCG Administration is administratively and operationally better suited to play this clearinghouse role than the HCG plans. This change in the HCG Administration's role is a reflection of the transition of the HCG program from simply a health insurance vehicle for small employers to a health insurance program that provides subsidized coverage. The subsidies should be directed to those employees who are most in need: low income employees in small employers who have no other programs available to them. The shift to means-testing based on income requires a sophisticated interface at a program level with AHCCCS eligibility. Thus, the HCG Administration, based on it proven track record of administrative efficiency, should assume the clearinghouse role for the HCG program. Again, for HCG Administration to undertake these additional administrative functions would require a substantial expansion of their administrative dollars and resources. To do this, additional administrative funding sources would need to be identified. Currently, the HCG Administration is funded completely out of member contributions and this funding would be insufficient to cover the additional responsibilities proposed here.

Table 1. Summary – Proposed Division of HCG Responsibilities

HCG Administration	HCG Plans
Program Design	Network Development
Eligibility Determination (Only those ineligible for Public Programs)	Provider Credentialing
Premium Collection	Coordination of Care
Enrollment/Disenrollment	Disease Management
Marketing	Claims Payment
Rate Setting	Utilization Management
	Management Reporting

Underwriting Methodology

The current underwriting methodology is based upon a three-tiered premium structure that varies by age. It is not sophisticated enough to account for the proposed hierarchical eligibility process or the means-testing to determine the amount of subsidy. To incorporate accountability (for the current State subsidies) into the program, it is essential to have a premium structure that varies by income. A revised underwriting methodology is necessary to develop a premium structure that varies by income. To avoid issues of adverse selection, the underwriting methodology must also factor in demographic age banding.

The resulting new rate setting methodology would be comprised of a base three-tier rate structure that would vary slightly by county and two adjustment factors based on the employee's household income and the employee's age. Table 2 below shows how the proposed underwriting methodology would work.

Table 2. Summary – Revised Underwriting Methodology for Proposed Plan

	Tier Structure	Income Factor[1]	Demographic Factor[2]
Underwriting Variables	Employee Employee + One Employee + Family	0-299 % FPL 300-399 % FPL 400% +	18-34 35-44 45-54 55-64 65 +
[1] Income Factor would be based on the Employee's Household Income [2] Demographic Factor would be based on the Employee's Age			

Prepaid Plan

To reinforce the personal responsibility approach, HCG will continue to be a prepaid plan. The member's premium is due at the first of the month prior to the month of coverage. Members have up until the last day of the month prior to the coverage month before being disenrolled for non-payment of premium.

Key Focus for Arizona Policy Makers – Program Design

To ensure the continued participation of the current HCG plans, it is critical that the HCG program design contain the following features;

- Hierarchical Eligibility – ensure that State-only dollars are used only for those with no other options
- Single Plan Offered Statewide – administrative and operational simplification
- Division of HCG Responsibilities – HCG Administration should assume all of the functions of a clearinghouse for the program and the HCG Plans should focus on access to care and service delivery
- Revised Underwriting Methodology-premium structure that includes factors for income and age/sex so that rates paid by employees vary by their household income and the employee's age
- Prepaid Plan – Just like any other employer-sponsored coverage, members must per pay their premiums.

Target Population

The target population for the HCG population continues unchanged from that of the current legislation; the small employer group marketplace with between 1 and 50 employees. The only exception to the employer size is in the instance of political subdivisions. HCG's legislation also includes as a covered group political subdivisions regardless of size.

To maximize potential participation and to reach lower income individuals, the proposed eligibility criteria would now include all employees who work at least 20 hours per week. Small employers are more likely to employ part-time workers (defined as anyone working less than 32 hours per week). Reducing the number of hours worked to 20 per week is a return to the eligibility criteria in effect prior to 1998. By including eligibility down to 20 hours per week, we are potentially including a vulnerable population that is not currently covered by existing public programs.

The participation requirements, continue to remain the same;

- Group Size 1-5 – required participation of 100%
- Group Size 6-50 – required participation of 80%

These requirements are designed to avoid adverse selection issues and would need to factor in any employees that were excluded from HCG as a result of being eligible for a joint State/Federal health care program.

Key Focus for Arizona Policy Makers – Target Population

To ensure the continued participation of the current HCG plans, it is critical that the HCG target population be based on the following criteria;

- Small Employers – groups of 1-50
- Hours Worked – any employee working more than 20 hrs per week
- Participation Requirements – 100% for groups 1-5, 80% for groups 6-50
- Political subdivisions of any size

Benefit Package

Overall, the Proposed Plan benefits package is comparable to private commercial insurance available to small employers in the Arizona health care market. Specifics will be discussed under each subheading listed below:

- Covered Services—inclusions/exclusions of services included within the plan, clinical appropriateness of services, focus on preventive services;
- Benefit Levels—types of and any limitations on the reimbursement amounts; and
- Copay Provisions – amount of up-front costs to receive services

Covered Services

The Covered Services section deals with the inclusion and exclusion of specific services in the benefit package. This section has been separated into two categories: basic services and preventive services.

Basic Services

As mentioned above, the covered services in the Proposed Plan are comparable to those available in the small group marketplace. As a result, the covered service package is quite comprehensive, including such key features as inpatient hospitalization, outpatient services, physician visits, maternity care, and pharmacy services. Exclusions, such as chiropractic care, behavioral health/substance abuse services, transplants, and skilled nursing facility admissions, will keep the premiums down, but will deter some individuals from enrolling in the Proposed Plan.

To ensure that the benefit plan is uniform Statewide and is consistent with that currently available in the small group marketplace, the benefit package will be expanded to add medically necessary durable medical equipment and family planning services. Both have been proven empirically to be cost-effective services and merit inclusion in the Proposed Plan's benefit package.

As a general note, the description of the benefit package may be changed in order to highlight important inclusions, as well as exclusions. For example, therapies may be included, but specific types of therapy, such as physical, speech, and occupational therapy, or even cardiac and pulmonary rehabilitation, should be specifically mentioned. Also, some of the typical exceptions, such as birth control medication, blood products, diabetic monitoring equipment, and cosmetic surgery, should be addressed at some point. By improving the detail of the covered services, individuals (as well as interested insurance plans) will have fewer questions and concerns with the policy.

Preventive Services

Preventive services, including routine physical exams, immunizations, well child care, and well women care are included in the Proposed Plan. This kind of preventive service is covered in the Proposed Plan and includes financial incentives designed to encourage participation in these preventive services. The preventive services, including well-care, screenings, and prenatal visits include financial incentives to participate. Examples of preventive services might include:

- Well Child Care— $10 copay;
- Well Woman Care— $10 copay;
- Prenatal Visits— $10 copay only for initial visit, waived for all subsequent visits,
- Cancer and/or Diabetes Screenings— $10 copay.

Benefit Levels

The Proposed Plan has a lifetime maximum benefit of $2,000,000, which is consistent with current practices in the small group marketplace.

Copays

The Proposed Plan changes the copay for a number of services to bring them more in line with current practice and the standard in the small group marketplace.

Physician Services

To be consistent with trends in the current marketplace towards increasing physician copays, the Proposed Plan includes a higher copay for physician visits, from $10 to $20 per visit. For any physician encounter other than a preventive visit from a pre-defined, approved list of scheduled preventive visits, the copay will be $20 per encounter.

Preventive Services

To encourage participation in preventive services, the Proposed Plan has reduced copays, $10, for all preventive visits from a pre-defined approved list of scheduled preventive visits. This would include well-care visits such as immunizations, well-woman care and well-child care visits. In addition, to encourage appropriate prenatal visits and follow-up, the Proposed Plan eliminates all copays for prenatal visits after the initial visit for the term of the pregnancy and for 60 days post-partum.

Emergency Room (ER)

To be consistent with trends in the current marketplace towards increasing ER copays, the Proposed Plan includes a higher copay for ER usage, from $50 to $100 per visit. Consistent with the current plan, the Proposed Plan does not include a copay differential for ER use based on the subjective determination of emergent vs. non-emergent conditions. Any use of the ER is subject to a $100 per use copay, to be waived if the individual is admitted to the hospital.

Pharmacy

Currently, pharmacy is experiencing the highest trend rate of any health care service, typically ranging from 16% to 20%. In a move to contain pharmacy costs, the majority of employer-sponsored health care programs have instituted substantial changes to their pharmacy programs in the last two years. To be consistent with trends in the current marketplace towards increasing pharmacy copays, the Proposed Plan includes a higher copay for prescription, from $5 for all prescriptions to a two-tiered approach. The most prevalent change in the marketplace has been to implement multi-tiered copayment programs in pharmacy to encourage the use of generic equivalents when they are clinically equivalent to brand name drugs. To be consistent with this trend in the marketplace, the Proposed Plan includes a two-tiered copay approach for pharmacy; $15 copay for generic drugs and $30 copay for brand name drugs.

Key Focus for Arizona Policy Makers – Benefits Package

The Proposed Plan does not make major changes to the benefits package. Standardizing the benefit package Statewide and increasing the copays make the plan design more consistent with that of the small group marketplace;

- Standardized benefit package – To ensure there are no differences Statewide, medically necessary DME and family planning services are added to the benefit package
- Copays–To bring the copays more in line with that of the private small employer marketplace, the copay for ER is increased to $100, regardless of emergent or non-emergent use and the pharmacy copays are changed to a two-tiered model featuring a $15 copay for generic drugs or a $30 copay for brand name drugs

Service Delivery Network

There were several issues around the service delivery network discussed by the HCG Administration and the HCG Plans, including the types of networks allowed, rural issues, and the type of coordination of care expected.

Single vs. Multiple Forms of Networks

The decision to offer a single form of service delivery network, as with that of plan design, has many implications, both positive and negative. Again, individual participation will likely be better when more than one type of service delivery network is offered. Because the uninsured sub-populations have different needs and concerns, it is beneficial to include various forms of coverage. In addition, competition could be increased as health maintenance organizations (HMOs) and indemnity plans contend for enrollment which could result in greater member participation.

However, offering more than one form of network does have its drawbacks. Any added programmatic options like network design will make the program more complex for the State to administer, the HMOs to operationalize, and members to understand. Likewise, more educational materials will need to be developed and distributed in order to aid individuals in choosing a specific form of network. Even with educational material, the complexity of the choices may lead to misunderstanding. Furthermore, the risk of the populations enrolling in the various networks may vary dramatically. This occurrence, often referred to as selection, can create significant imbalances between the indemnity, preferred provider organization (PPO), and HMO plans. These imbalances lead to higher costs in certain plans and create concerns for insurance providers that are left with the highest cost individuals.

It is not typical of other subsidized state plans to include both an indemnity and HMO option. They generally offer only one option and that choice is dictated by the

predominant service delivery mechanism in the State. Looking to the employer-sponsored marketplace in general, only 4 percent of small to large employers (0–99 and 100–499 employees) nationally offer both indemnity and managed care plans, while 18 percent offer multiple forms of managed care plans (e.g., HMO, PPO, Point of Service). These percentages are 17 percent and 36 percent respectively for very large employers (500+ employees) (Source: Mercer/Foster Higgins National Survey of Employer-Sponsored Health Plans 2000).

Coordination of Care

The contracted health plans will be responsible for coordinating the care of the HCG members. While often considered a hassle to the insured, this coordinated approach to care delivery can save money and lead to a higher quality of care due to provider coordination. Likewise, a lack of coordination can lead to duplication of services and unnecessary treatments.

Rural Issues

An HMO model is not always feasible in rural areas, due to relatively few health care providers and hospitals. HMOs need these providers and hospitals in their network, but are often unable to negotiate discounted rates due to the lack of competition among providers. PPO plans have the same concern in rural areas, since they are dependent, in large part, on their network of providers and related discounted fees. Thus, PPO and HMOs plans are typically not offered in rural areas. However, Arizona's Medicaid program, based upon an HMO coverage model, has been successful in extending managed care to the rural areas. These Medicaid managed care plans are currently participating in every Arizona County. Currently, the two contracted HCG plans do not cover every Arizona County. The HCG Administration needs to secure additional HMOs on a county-by-county basis to offer true statewide coverage.

Key Focus for Arizona Policy Makers – Service Delivery Network

To ensure the continued participation of the current HCG plans, it is critical that the HCG program include the following service delivery requirements;

- Single Delivery Mechanism – to avoid any adverse selection within the HCG program, only a managed care service delivery network should be offered
- Care Coordination – again to avoid any adverse selection within the HCG program, only a gatekeeper model should be utilized to coordinate care
- Rural Issues – in the event sufficient HMO coverage is not attainable, the HCG Administration may want to consider indemnity coverage on a county-by-county basis

Personal Responsibility Components

The original intent of the HCG enabling legislation was to provide a health insurance vehicle to those small employers for whom health insurance was not available, either due to a lack of product availability or affordability. The program was designed to provide a vehicle for small employers to offer health insurance where previously they had none with little or no subsidy from the State. Small employers and their employees would be personally responsible for the vast majority of their health care costs.

As mentioned above, all individuals who apply to the HCG program through their employers must submit adequate documentation for the HCG administration to determine their eligibility for other joint State/Federal programs. To ensure that State-only dollars are used only those individuals for whom no other publicly funded health insurance options exist, only those individuals who are ineligible for Federal programs will be enrolled in the HCG program.

The premium structure will use a incremental scale based on household income and employee age. As a result of implementing hierarchical eligibility, the scale will be coordinated with existing State/Federal programs' income eligibility guidelines. For the income factor, as your household income increases, so will your premium. The sliding scale will be sloped so that the low income households (less than 300% of the FPL) will be receiving the largest subsidy, the near poor (between 300% and 399%) will receive a smaller subsidy, and those with incomes above 400% will receive no subsidy and could potentially be subsidizing the cost of the program.

Appendix 1: Proposed Plan – Benefit Package

Plan Features and Benefits		HCG HMOs Benefit Package
Calendar Year Deductible	Individual	Not Applicable
	Family Aggregate	Not Applicable
Physician Services	Office Visit + Minor Surgical	$20 Copay per Encounter
	Any Physician Services other than approved, scheduled preventive visits	$20 Copay per Encounter
	Preventive Visits from an approved, scheduled list	$10 Copay per Encounter
	Maternity Services, including Prenatal/Postnatal Care, Labor and Delivery	$20 Copay for first visit only, copay waived for remainder of visits during pregnancy and 60 days post-partum
Other Services	Diagnostic Lab and X-ray Services	Copay waived
Additional Services	Medically Necessary DME	Not Applicable
	Family Planning Services	$20 Copay
Hospital Services	Inpatient Room and Board, Lab and X-ray Medical Supplies, and Miscellaneous Hospital Services	$100 Copay Per Admission
	Licensed Ambulatory Surgical Center	$100 Copay Per Surgery
Emergency Care	Physicians Office	$20 Copay
	Urgent Care Center	$40 Copay
	Hospital	$100 Copay (Waived if admitted)
	Ambulance	No Charge if Authorized by Health Plan
Prescriptions		$15 generic and $30 brand Copay at a Participating Pharmacy

Plan Features and Benefits		HCG HMOs Benefit Package
Out-of-Pocket Limit		Individual—200% Annual Premium Family—200% Annual Premium
	Lifetime Maximum Benefit	$2 million